INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health State Form 51000 (R/10-05)

DIRECTIONS - PLEASE READ BEFORE YOU BE	GIN:		
1 Print firmly and neatly. 3 Fill in circles like the	all items on forms		
• · · ·	and numbers completely all items on form. Date format:		
Wark inistakes like	,		
Section 1. Demographic Information			
	IODII Antinus C. A cons. C. Not o cons		
Last Name			
First Name MI Phone Number			
Number & Street Address			
City	State ZIP Code		
County	Date of Birth Age		
Race:	Ethnicity: Is Age in		
O Asian O White O Black or African American O Other/Mul	O Hispanic or Latino O Not Hispanic or Latino O Unknown		
O American Indian or Alaska Native O Unknown	O Months		
O Native Hawaiian or Other Pacific Islander	○ Male ○ Female ○ Unknown ○ Years		
	Section 2. Clinical Information		
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Date of Onset	Section 2. Clinical Information		
Date of Onset	Section 2. Clinical Information		
Date of Onset Was the patient hospitalized?			
Date of Onset Was the patient hospitalized?	nission date:		
Date of Onset Was the patient hospitalized? O Yes O No If Yes, adm			
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Date of Onset Was the patient hospitalized? O Yes O No If Yes, adm Dis Patient ch	nission date: /		
Date of Onset Was the patient hospitalized? O Yes O No If Yes, adm Dis Patient ch	nission date: /		
Date of Onset Was the patient hospitalized? O Yes O No If Yes, adm Dis Patient ch Phys Outcome: O Survived O Died O Unknown	nission date: /		

INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 2 of 4

Indiana State Department of Health State Form 51000 (R/10-05)

Section 2. Clinical Informa	ation (continued)
Symptoms (check all that apply): O Headache	Specimen from which <i>Neisseria meningitidis</i> was isolated (check all that apply):
O Stiff Neck	O CSF
○ Fever (degrees) ○ Malaise	O Blood
O Rash, describe:	O Not Isolated
	O Other, specify:
○ Vomiting○ Nausea	
O Flu-like Symptoms	If N. meningitidis was not isolated, diagnosis
O Confusion	was made by:
O Coma	O Detecting Positive Antigen in CSF or
Other, specify:	O Clinical Purpura Fulminans
Specify underlying medical conditions:	
	in Deficiencies O Anatomic or Functional Asplenia None O Unknown O Other
If Other, specify	
Neisseria meningitidis serogroup:	
O A O B O C O Y O W135 O Not Groupable	O Unknown or Not Done O Other
Type of infection caused by <i>N. meningitidis:</i> O Bacteremia O Pneumonia O Purpura Fulminans	O Peritonitis
O Meningitis O Septic Arthritis O Pericarditis	O Other
Resistant to Sulfa?	
O Yes O No O Not Tested or Unknown	
Resistant to Rifampin?	
○ Yes ○ No ○ Not Tested or Unknown	
Resistant to Penicillin?	
O Yes O No O Not Tested or Unknown	

INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 3 of 4

Indiana State Department of Health State Form 51000 (R/10-05)

Section 3. Other Case Information and Contact Assessment **Employment Status:** O Full-time O Part-time O Unemployed If employed, name of employer Type of employment Job duties Does this patient attend school or day care? O Yes O No O Unknown If Yes, name of school/day care Address **Contact name Contact phone** Does this patient attend a college or university? O Yes O No O Unknown If Yes, name of college/university Address **Contact name** Contact phone Year in college/university? O Freshman O Senior O Sophomore O Junior O Other College/University housing? O Dormitory O Apartment O Single Family Home with Family O Single Family Home with Student O Other If Other, specify Has the patient traveled outside of the county in the past 14 days? O Yes O No O Unknown If Yes, specify travel location(s) ___/_/____/_____ to Travel dates: From Mode of transportation? O Automobile O Train O Bus O Airplane

INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 4 of 4

Indiana State Department of Health State Form 51000 (R/10-05)

Section 3. Other Case Information and Contact Assessment (continued) For airplane travel, specify: Was flight 8 hours or longer (including ground time)? O Yes O No If Yes, airline name Flight number Has the patient ever received meningococcal vaccine? O Yes O No Unknown If Yes, reason for vaccine? O College Entrance O Travel O Functional or Anatomic Asplenia O Other If Other, specify Section 4. Additional Close Contact Assessment In the 7 days prior to illness onset, did any of the following transmission risks exist (check all that apply)? Household exposures: O Sleepovers O Military Service O Jail/Prison O Shelter O Other If Other, specify **Sharing secretions:** Kissing O Shared Toothbrush O Shared Food/Drink O Shared Drugs O Shared Band Instruments O Shared Cigarettes O Shared Utensils O Other If Other, specify Section 5. Comments/Follow-up Comments: **Investigator Name** Agency ___/__/____ **Phone Number**